EXHIBIT B

disabilities, that are 100% disabling; or

- You are totally disabled based on an individual unemployability determination.

Actions to Take:

- Complete sections 1 through 3 of your TPD discharge application
- Return the application along with a copy of the complete documentation of your VA determination (as described earlier) to the address below

Note: If you provide the VA documentation described earlier, you are **not** required to have a physician complete Section 4 of the application.

2 - Social Security Administration Determination:

If you are receiving SSDI or SSI benefits, you will be considered totally and permanently disabled for the purposes of this discharge if you provide an SSA notice of award for SSDI or SSI benefits stating that your next scheduled disability review will be within 5 to 7 years from the date of your most recent SSA disability determination.

If your SSA notice of award does not indicate when your next scheduled disability review will occur, you can obtain this information by calling your local SSA office or by calling 800.772.1213 and requesting a Benefits Planning Query. The Benefits Planning Query will show when your next review is scheduled to occur.

Actions to Take:

- Complete sections 1 through 3 of your TPD discharge application
- Return the application along with a **complete** copy of your SSA notice of award (as described earlier) or, if applicable, your Benefits Planning Query to the address below

Note: If you provide the SSA documentation described earlier, you are **not** required to have a physician complete Section 4 of the application

3 - Physician Certification:

Alternatively, to show that you are totally and permanently disabled for the purposes of this discharge, you may submit the TPD discharge application with a certification from a physician that shows you are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that (1) can be expected to result in death; (2) has lasted for a continuous period of not less than 60 months; or (3) can be expected to last for a continuous period of not less than 60 months.

EXHIBIT C

OMB No. 1845-0065
Form Approved
Exp. Date 6/30/2016

DISCHARGE APPLICATION: TOTAL AND PERMANENT DISABILITY

William D. Ford Federal Direct Loan, Federal Family Education Loan, Federal Perkins Loan, and TEACH Grant Programs

WARNING: Any person who knowingly makes a false statement or misrepresentation on this form or on any accompanying documents will be subject to penalties that may include fines, imprisonment, or both, under the U.S. Criminal Code and 20 U.S.C. 1097.

SECTION 1: APPLICANT IDENTIFICATION

Please enter or correct the following information.

☐ Check this box if any of your information has changed.

SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___

DOB ___ ___ - ___ ___ - ___ ___ ___ ___

Name _____

Address _____

City, State, Zip Code _____

Telephone ( ) _____

E-mail Address (Optional) _____

SECTION 2: INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Carefully read the entire application, including page 1, the instructions in this section, and the additional information on the following pages.
- Type or print in dark ink. Sign and date the application in Section 3. If you are required to have a physician complete Section 4, enter your name and Social Security Number at the top of page 2 (if not preprinted).
- Send the completed application with any required documentation to:

U.S. Department of Education, TPD Servicing, PO Box 87130, Lincoln, NE 68501-7130

1. Are you a veteran who has received a determination from the U.S. Department of Veterans Affairs (VA) that you are **unemployable due to a service-connected disability?**
   - ☐ Yes – Attach documentation of the VA determination and complete Section 3. **You are not required to have a physician complete Section 4.**
   - ☐ No – Continue to Item 2.
2. Have you received an SSA notice of award for SSDI or SSI benefits or an SSA Benefits Planning Query (BPQY) stating that **your next scheduled disability review will be 5 to 7 years or more from the date of your last SSA disability determination?**
   - ☐ Yes – Attach a copy of the SSA notice of award or BPQY and complete Section 3. **You are not required to have a physician complete Section 4.**
   - ☐ No – Complete Section 3 and **have a physician who is a doctor of medicine or osteopathy complete and sign Section 4. You must submit this application to us within 90 days of the date of your physician's signature in Section 4.**

SECTION 3: APPLICANT'S DISCHARGE REQUEST, AUTHORIZATION, UNDERSTANDINGS, AND CERTIFICATIONS

I request that the U.S. Department of Education discharge my Direct Loan, FFEL, and/or Perkins Loan, program loan(s), and/or my TEACH Grant service obligation.

I authorize any physician, hospital, or other institution having records about the disability that is the basis for my request for a discharge to make information from those records available to the U.S. Department of Education.

I understand that:

(1) If I am applying for discharge based on a physician's certification in Section 4, I must submit this application to the U.S. Department of Education within 90 days of the date of my physician's signature in Section 4.

(2) Unless I am a veteran who provides the documentation described above in Section 2, Item 1, I may be required to repay a discharged loan or satisfy a discharged TEACH Grant service obligation if I fail to meet certain requirements during a post-discharge monitoring period, as explained in Section 6.

(3) If I am a veteran who does not meet the requirement described above in Section 2, Item 1, and I have obtained a certification from a physician in Section 4, the certification by the physician on this form is only for the purposes of establishing my eligibility to receive a discharge of a Direct Loan Program loan, a FFEL Program Loan, a Perkins Loan Program loan, and/or a TEACH Grant service obligation, and is not for purposes of determining my eligibility for, or the extent of my eligibility for, VA benefits.

(4) If I wish to designate an individual or organization to represent me in matters related to my total and permanent disability discharge request, I must complete and submit the Total and Permanent Disability Discharge: Applicant Representative Designation form.

I certify that: **(1)** I have a total and permanent disability, as defined in Section 5; and **(2)** I have read and understand the information on the discharge process, the terms and conditions for discharge, and the eligibility requirements to receive future loans or TEACH Grants as explained in Sections 6 and 7.

Signature of Applicant or Applicant's Representative (see NOTE below) _____ Date _____ Printed Name of Representative (if applicable) _____

NOTE: You may designate an individual or organization to represent you in matters related to your total and permanent disability discharge request. If you wish to designate a representative, you must complete the Total and Permanent Disability: Applicant Representative Designation form. You may obtain this form from our Total and Permanent Disability Discharge Servicer. See the "Read This First" section of this form for contact information.

Applicant Name: _____ Applicant SSN: ___ - ___ - ____

SECTION 4: PHYSICIAN'S CERTIFICATION

Information and Instructions for Physician:

- The applicant identified above is applying for a discharge of a federal student loan and/or a teaching service obligation for a federal grant on the basis that he or she has a total and permanent disability, as defined in Section 5 of this form. To qualify for a discharge, the applicant must be unable to engage in any substantial gainful activity (as defined below and in Section 5) by reason of a medically determinable physical or mental impairment that **(1)** can be expected to result in death; or **(2)** has lasted for a continuous period of not less than 60 months; or **(3)** can be expected to last for a continuous period of not less than 60 months. This disability standard may be different from standards used under other programs in connection with occupational disability, or eligibility for social service or veterans benefits. A determination that the applicant is disabled by another federal agency (for example, the Social Security Administration) or a state agency does not automatically establish the applicant's eligibility for this loan discharge.
- Complete this form only if you are a doctor of medicine or osteopathy legally authorized to practice in a state, as defined in Section 5, and only if the applicant's condition meets the definition of total and permanent disability in Section 5.
- **Print legibly in dark ink or type. All fields must be completed. If a field is not applicable, enter "N/A." Your signature date must include month, day, and year (mm-dd-yyyy).**
- Provide all requested information for Items 1, 2, and 3 below, and attach additional pages if necessary. Complete the physician's certification at the bottom of this page. The applicant's loan discharge application cannot be processed if the information requested in this section is missing or if your signature is missing.
- If you make any changes to the information you provide in this section, you must initial each change.
- **Please return the completed form to the applicant or the applicant's representative.** The U.S. Department of Education may contact you for additional information or documentation.

1. Medically Determinable Physical or Mental Impairment. Does the applicant have a medically determinable physical or mental impairment that **(a)** prevents the applicant from engaging in any substantial gainful activity, in any field of work, and **(b)** can be expected to result in death, *or* has lasted for a continuous period of not less than 60 months, *or* can be expected to last for a continuous period of not less than 60 months?

☐ Yes ☐ No

Substantial gainful activity means a level of work performed for pay or profit that involves doing significant physical or mental activities, or a combination of both. *If the applicant is able to engage in any substantial gainful activity, in any field of work, you must answer "No." The determination of whether or not the applicant can perform substantial gainful activity is not based on whether the applicant can perform his or her current or past job or profession.*

IF THE ANSWER TO QUESTION 1 IS NO, DO NOT COMPLETE THIS APPLICATION.

2. Disabling Condition. Complete Items **(a)** and **(b)** regarding the applicant's disabling impairment. **Do not use abbreviations or insurance codes.**

(a) Provide your diagnosis of the applicant's impairment: _____

(b) Describe the severity of the disabling physical or mental impairment, including, if applicable, the phase of the disabling condition: _____

3. Limitations. Explain how the disabling condition prevents the applicant from engaging in substantial gainful activity in any field of work by responding to Items **(a)** through **(e)** below, as relevant to the applicant's condition. Attach additional pages if more space is needed.

In addition to what is required below, you may include any additional information that you believe would be helpful in understanding the applicant's condition, such as medications used to treat the condition, surgical and non-surgical treatments for the condition, etc.

(a) Limitations on sitting, standing, walking, or lifting: _____

(b) Limitations on activities of daily living: _____

(c) Residual functionality: _____

(d) Social/behavioral limitations, if any: _____

(e) Current Global Assessment Function Score (for psychiatric conditions): _____

Physician's Certification

- **I certify** that, in my best professional judgment, the applicant identified above is unable to engage in any substantial gainful activity in *any* field of work by reason of a medically determinable physical or mental impairment that **(1)** can be expected to result in death; or **(2)** has lasted for a continuous period of not less than 60 months; or **(3)** can be expected to last for a continuous period of not less than 60 months.
- **I understand** that an applicant who is currently able to engage in any substantial gainful activity in *any* field of work does not have a total and permanent disability as defined on this form.

I am a doctor of (check one) ☐ medicine ☐ osteopathy/osteopathic medicine.

I am legally authorized to practice in the state identified below and I have provided my professional license number below.

State Where Legally Authorized to Practice _____ Professional License Number(stamp is acceptable; subject to verification through state records) _____

Physician's Signature (a signature stamp is not acceptable) _____ Date (mm-dd-yyyy) _____ Printed Name of Physician (first name, middle initial, last name) _____

Address (stamp is acceptable) _____ City, State, Zip Code _____

( ) _____ Telephone ( ) _____ Fax E-mail Address (Optional) _____